GlobalHealth of Texas

Medicare Office Reference Manual

Global Classic (HMO) 001
Global Classic (HMO) 003
Global Special Care (HMO C-SNP)
Global Special Care Savings (HMO C-SNP)

PO Box 2906

Milwaukee, WI 53201-2906

888.308.9345

www.dentaquest.com

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Address and Quick Reference Telephone Numbers

DentaQuest Provider Services:
1.888.308.9345

DentaQuest Member Services:
1.833.493.0566

GlobalHealth Medicare Member Services:
1.844.200.8167
FAX: 405.280.5294

TTY:
711

Fraud Hotline
1.800.237.9139

DentaQuest Member and Provider Website:
http://www.dentaquest.com/Texas

Authorizations should be sent to:
DentaQuest-Authorization
PO Box 2906
Milwaukee, WI 53201-2906
Fax: 1.262.241.7150 or 1.888.313.2883

Credentialing applications should be sent to:
DentaQuest-Credentialing
PO Box 2906
Milwaukee, WI 53201-2906
Credentialing Hotline: 1.800.233.1468
Fax: 1.262.241.4077

Claims should be sent to:
DentaQuest-Claims
PO Box 2906
Milwaukee, WI 53201-2906

Electronic Claims should be sent: Direct entry on the web – **www.dentaquest.com**

Or:

Via Clearinghouse – Payer ID CX014 Include address on electronic claims:
DentaQuest, LLC
PO Box 2906
Milwaukee, WI 53201-2906

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Office Reference Manual
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Statement of Rights and Responsibilities

The mission of DentaQuest is to expand access to high-quality, compassionate healthcare services. DentaQuest is committed to ensuring that all Members are treated in a manner that respects their rights and acknowledges its expectations of Member's responsibilities. The following is a statement of Member's rights and responsibilities.

1. All Members have a right to receive pertinent written and up-to-date information about DentaQuest, the managed care services DentaQuest provides, the Participating Providers and dental offices, as well as Members rights and responsibilities.

2. All Members have a right to privacy and to be treated with respect and recognition of their dignity when receiving dental care.

3. All Members have the right to fully participate with caregivers in the decision-making process surrounding their health care.

4. All Members have the right to be fully informed about the appropriate or medically necessary treatment options for any condition, regardless of the coverage or cost for the care discussed.

5. All Members have the right to voice a complaint against DentaQuest, or any of its participating dental offices, or any of the care provided by these groups or people, when their performance has not met the Member's expectations.

6. All Members have the right to appeal any decisions related to patient care and treatment. Members may also request an external review or second opinion.

7. All Members have the right to make recommendations regarding DentaQuest's/Plan's Members' rights and responsibilities policies.

8. All Members have the right to ask that a specific Provider be added to the participating network.

9. All Members have the right to request and receive a copy of your medical /dental records and to request that they be changed or corrected.

10. All Members have the right to exercise your rights without being treated differently.

11. All Members have the right to be free from any form of restraint or seclusion used to convince you to do something you may not want to do, or as punishment.

Likewise:

1. All Members have the responsibility to provide, to the best of their abilities, accurate information that DentaQuest and its participating Providers need in order to provide the highest quality of health care services.

2. All Members have a responsibility to closely follow the treatment plans and home care instructions for the care that they have agreed upon with their health care practitioners.

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3. All Members have the responsibility to participate in understanding their health problems and developing mutually agreed upon treatment goals to the degree possible.

4. All Members have the responsibility to know their medications and inform the Provider of their medication.

5. All Members have the responsibility to make sure to understand information and instructions given by your Provider.

6. All Members have the responsibility to be courteous to the Provider and to other patients by arriving 10 minutes early for their appointment and to call the dental office at least 24 hours in advance if they cannot keep their appointment.

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Statement of Provider Rights and Responsibilities

Providers shall have the right to:

1. Communicate with patients, including Members regarding dental treatment options.
2. Recommend a course of treatment to a Member, even if the course of treatment is not a covered benefit or approved by Plan/DentaQuest.
3. File an appeal or complaint pursuant to the procedures of Plan/DentaQuest.
4. Supply accurate, relevant, factual information to a Member in connection with an appeal or complaint filed by the Member.
5. Object to policies, procedures, or decisions made by Plan/DentaQuest.
6. If a recommended course of treatment is not covered, e.g., not approved by Plan/DentaQuest, the Participating Provider must notify the Member in writing and obtain a signature of waiver if the Provider intends to charge the Member for such a non-compensable service.

* * *

DentaQuest makes every effort to maintain accurate information in this manual; however, will not be held liable for any damages directly or indirectly due to typographical errors. Please contact us should you discover an error.

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1.0 Patient Eligibility Verification Procedures

1.01 Plan Eligibility

Any person who is enrolled in a Plan's program is eligible for benefits under the Plan certificate

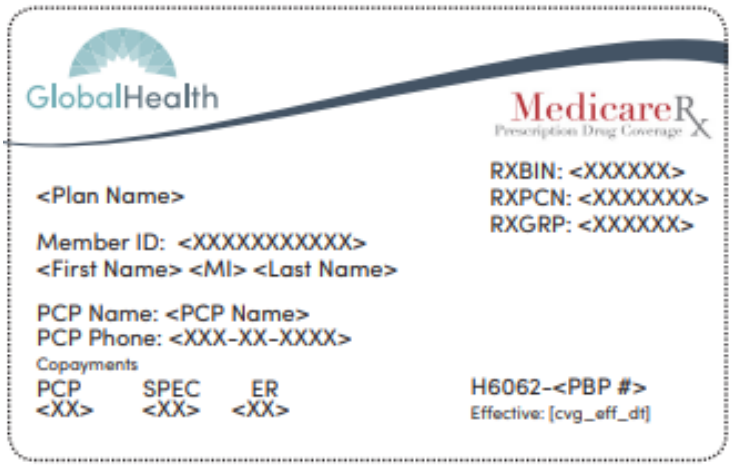
1.02 Member Identification Card

Health plan members receive identification cards from the Plans. Participating Providers are responsible for verifying that Members are eligible at the time services are rendered and to determine if recipients have other health insurance.

Please note that due to possible eligibility status changes, this information does not guarantee payment and is subject to change without notice.

DentaQuest recommends that each dental office make a photocopy of the member's identification card each time treatment is provided. It is important to note that the health plan identification card is not dated, and it does not need to be returned to the health plan should a member lose eligibility. Therefore, **an identification card in itself does not guarantee that a person is currently enrolled in the health plan.**

Sample ID Card:



1.03 DentaQuest Eligibility Systems

Participating Providers may access member eligibility information through DentaQuest's Interactive Voice Response (IVR) system or through the "Dentist" section of DentaQuest's website at **www.dentaquest.com**. The eligibility information received from either system will be the same information you would receive by calling DentaQuest's Customer Service department; however, by utilizing either system you can get information 24 hours a day, seven days a week without having to wait for an available Customer Service Representative.

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Access to eligibility information via the Internet

DentaQuest's Internet currently allows Providers to verify a Member's eligibility as well as submit claims directly to DentaQuest. You can verify the Member's eligibility on-line by entering the Member's date of birth, the expected date of service and the Member's identification number or last name and first initial. To access the eligibility information via DentaQuest's website, simply log on to the website at **www.dentaquest.com**. Once you have entered the website, click on "Dentist". From there choose your 'State" and press go. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and ZIP code. If you have not received instruction on how to complete Provider Self Registration, contact DentaQuest's Customer Service Department. Once logged in, select "Eligibility look up" and enter the applicable information for each Member you are inquiring about. You can check on an unlimited number of patients and print off the summary of eligibility given by the system for your records.

Access to eligibility information via the IVR line

To access the IVR, simply call DentaQuest's Customer Service department and press 1 for eligibility. The IVR system will be able to answer all of your eligibility questions for as many members as you wish to check. Once you have completed your eligibility checks, you will have the option to transfer to a Customer Service Representative to answer any additional questions, i.e. member history, which you may have. Using your telephone keypad, you can request eligibility information on a Medicare member by entering your six-digit DentaQuest location number, the member's recipient identification number and an expected date of service. After our system analyzes the information, the patient's eligibility for coverage of dental services will be verified. If the system is unable to verify the member information you entered, you will be transferred to a Customer Service Representative.

Directions for using DentaQuest's IVR to verify eligibility:
Entering system with Tax and Location ID's

1. Call DentaQuest Customer Service.
2. After the greeting, stay on the line for English or press 1 for Spanish.
3. When prompted, press or say 2 for Eligibility.
4. When prompted, press or say 1 if you know your NPI (National Provider Identification number) and Tax ID number.
5. If you do not have this information, press or say 2. When prompted, enter your User ID (previously referred to as Location ID) and the last four digits of your Tax ID number.
6. Does the member's ID have **numbers and letters** in it? If so, press or say 1. When prompted, enter the member ID.
7. Does the member's ID have **only numbers** in it? If so, press or say 2. When prompted, enter the member ID.
8. Upon system verification of the Member's eligibility, you will be prompted to repeat the information given, verify the eligibility of another member, get benefit information, get limited claim history on this member, or get fax confirmation of this call.
9. If you choose to verify the eligibility of an additional Member(s), you will be asked to repeat step 5 above for each Member.

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Please note that due to possible eligibility status changes, the information provided by either system does not guarantee payment.

If you are having trouble accessing either the IVR or website, please contact the Customer Service Department. They will be able to help you use either system.

2.0 Member Organization Determinations, Appeals, and Grievances

You have the right to appeal to DentaQuest if you think:

- We have not paid a bill for services that we should have paid
- We have not paid a paid in full for services that we should have paid
- We have not provided or arranged for you to receive care that is covered
- We stopped providing care that you still need

We normally have 30 calendar days to process your appeal for any requests for payment. In some cases, you have a right to request a faster appeal known as an Expedited 72-Hour Appeal. You can get a fast appeal if your health or ability to function could be seriously harmed by waiting 30 calendar days for a standard appeal. If you ask for a fast appeal, we will decide if you get an expedited 72-hour fast appeal. If not, your appeal will be processed in 30 calendar days. If any physician asks for a fast appeal, and supports your request for a fast appeal, we must automatically give it to you.

2.01 Organization Determinations (OD)

- An OD is a determination made by DentaQuest with respect to any of the following:
    - The refusal to provide or pay for services, in whole or in part, including the type or level of services. That the member believes should be furnished or arranged for by the Medicare Advantage program.
    - Discontinuation of a service if the member believes that the continuation of the service is medically necessary.
    - Failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the member with timely notice of an adverse determination, such that a delay would adversely affect the health of the member.
    - The standard time frame for service requests is 14 calendar days from the date of request. The expedited time frame for service requests is 72 hours from the date of request

2.02 Complaint

- An expression of dissatisfaction. There are two types of procedures designed to address a Medicare Advantage member complaint: the Appeals process and the Grievance Process

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2.02.1 Medicare Member Appeals

Any of the procedures that deal with the review of adverse organization determinations on the health care services of an enrollee believes he or she is entitled to receive, including delay in providing, arranging or approving the healthcare services (such that delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service. Turnaround is 72 hours to 60 days. The resolution time frame may be extended by up to 14 calendar days if the Member or their representative request an extension or if additional information is needed and the extension is in the best interest of the Member

2.02.2 Medicare Member Grievance:

A communication by or on behalf of a member expressing dissatisfaction with any aspect of the plan's or contracted provider's operations, activities or behavior, other than one involving an organization determination, regardless or whether any remedial action is requested. This includes complaints about benefits, DentaQuest or GlobalHealth staff, Providers or balance billing amounts the member must pay for service. Turnaround time is 24 hours to 30 days. The resolution time frame may be extended by up to 14 additional calendar days if the Member or their representative requests an extension or if additional information is needed and the extension is in the best interest of the Member.

Member Grievances and Appeals should be directed to GlobalHealth

GlobalHealth
RE: Member CGA
PO Box 2658
Oklahoma City, OK 73101
844-200-8194

3.0 Provider Complaint and Claim Resolution Process:

3.01 Administrative Complaints

Complaints in reference to administrative functions, policies, and procedures of the company do not include claim denial issues.

Administrative complaints may be made verbally by calling DentaQuest at 855-453-5287.

3.02 Claim Resolution Process

Appeals in reference to a denial issued by Claims for any reason. Providers are offered 60 calendar days to file written appeals in reference to claim denials. DentaQuest will process provider claim appeals within 30 business days of receipt.

Claim Resolution Requests may be sent to DentaQuest in writing

DentaQuest, LLC
RE: Provider Claim Resolution
PO Box 2906
Milwaukee, WI 53201-2906

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4.0 Claim Submission Procedures (Claim Filing Options)

DentaQuest receives dental claims in 4 possible formats. These formats include:

- Electronic claims via DentaQuest's website (**www.dentaquest.com**)
- Electronic submission via clearinghouses
- HIPAA Compliant 837D File
- Paper claims via U.S. Postal Service or Fax **1-262-834-3589**

4.01 Submitting Claims with X-Rays

- Electronic submission using the Provider Web Portal (PWP)
- Electronic submission using National Electronic Attachment (NEA) is recommended. For more information, please visit www.nea-fast.com and click the "Learn More" button. To register, click the "Provider Registration" button in the middle of the home page.
- Submission of duplicate radiographs (which we will recycle and not return)
- Submission of original radiographs with a self-addressed stamped envelope (SASE) so that we may return the original radiographs. Note that determinations will be sent separately, and any radiographs received without a SASE will not be returned to the sender.

Please note we also require radiographs be mounted when there are five or more radiographs submitted at one time. If five or more radiographs are submitted and not mounted, they will be returned to you and your claims will not be processed. You will need to resubmit a copy of the 2018 ADA claim form that was originally submitted, along with mounted radiographs so that we may process the claim correctly.

Acceptable methods of mounted radiographs are:

- Radiographs duplicated and displayed in proper order on a piece of duplicating film.
- Radiographs mounted in a radiograph holder or mount designed for this purpose.

Unacceptable methods of mounted radiographs are:

- Cut out radiographs taped or stapled together.
- Cut out radiographs placed in a coin envelope.
- Multiple radiographs placed in the same slot of a radiograph holder or mount.

All radiographs should include Member's name, identification number and office name to ensure proper handling.

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4.02 Electronic Claim Submission Utilizing DentaQuest's Internet Website (Provider Web Portal)

Participating Providers may submit claims directly to DentaQuest by utilizing the "Dentist" section of our Provider Web Portal. Submitting claims via the website is very quick and easy. It is especially easy if you have already accessed the site to check a Member's eligibility prior to providing the service.

To submit claims via the portal, simply log on to **www.dentaquest.com**. Once you have entered the website, click on the "Dentist" icon. From there choose your State and press go. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. DentaQuest should have contacted your office in regards on how to perform Provider Self Registration or contact DentaQuest's Provider Service Department at **1-888-308-9345.** Once logged in, select "Claims/Pre-Authorizations" and then "Dental Claim Entry". The Provider Portal allows you to attach electronic files (such as X-rays in jpeg format, reports, and charts) to the claim.

If you have questions on submitting claims or accessing the portal, please contact our Systems Operations at **1-800-417-7140** or via e-mail at **EDITeam@greatdentalplans.com**

4.03 Electronic Claim Submission via Clearinghouse

DentaQuest works directly with Emdeon (**1-888-255-7293**), Tesia (**1-800-724-7240**), EDI Health Group (**1-800-576-6412**), Secure EDI (**1-877-466-9656**), and Mercury Data Exchange (**1-866-633-1090**) for claim submissions to DentaQuest.

You can contact your software vendor to make certain that they have DentaQuest listed as the payer and claim mailing address on your electronic claim. Your software vendor will be able to provide you with any information you may need to ensure that submitted claims are forwarded to DentaQuest. DentaQuest's Payer ID is CX014.

4.04 HIPAA Compliant 837D File

For Providers who are unable to submit electronically via the Internet or a clearinghouse, DentaQuest will work directly with the Provider to receive their claims electronically via a HIPAA compliant 837D or 837P file from the Provider's practice management system. Please email **EDITeam@greatdentalplans.com** to ask about this option for electronic claim submission.

4.05 NPI Requirements for Submission of Electronic Claims

In accordance with the HIPAA guidelines, DentaQuest has adopted the following NPI standards in order to simplify the submission of claims from all of our Providers, conform to industry required standards and increase the accuracy and efficiency of claims administered by DentaQuest.

- Providers must register for the appropriate NPI classification at **https://nppes.cms.hhs.gov/NPPES/Welcome.do** and provide this information to DentaQuest in its entirety.

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- All Providers must register for an Individual NPI. You may also be required to register for a group NPI (or as part of a group) dependent upon your designation.

- When submitting claims to DentaQuest you must submit all forms of NPI properly and in their entirety for claims to be accepted and processed accurately. If you registered as part of a group, your claims must be submitted with both the Group and Individual NPIs. These numbers are not interchangeable and could cause your claims to be returned to you as non-compliant.

- If you are presently submitting claims to DentaQuest through a clearinghouse or through a direct integration, you need to review your integration to assure that it is in compliance with the revised HIPAA compliant 837D format. This information can be found on the 837D Companion Guide located on the Provider Web Portal.

4.06 Paper Claim Submissions

- Claims must be submitted on a 2018 ADA claim form; and other forms as approved in advance by DentaQuest

- Member name, identification number and date of birth must be listed on all claims submitted. If the Member ID number is missing or miscoded on the claim form, the Member cannot be identified. This could result in the claim being returned to the submitting Provider office, causing a delay in payment.

- The paper claim must contain an acceptable Provider signature

- The Provider and office location information must be clearly identified on the claim. Frequently, if only the Provider signature is used for identification, the Provider's name cannot be clearly identified. Please include either a typed Provider (practice) name or the DentaQuest Provider identification number.

- The paper claim form must contain a valid Provider NPI (National Provider Identification) number. In the event of not having this box on the claim form, the NPI must still be included on the form. The 2018 ADA claim form only supplies 2 fields to enter NPI. On paper claims, the Type 2 NPI identifies the payee, and may be submitted in conjunction with a Type 1 NPI to identify the Provider who provided the treatment. For example, on a standard 2018 ADA Dental Claim Form, the treating Provider's NPI is entered in field 54 and the billing entity's NPI is entered in field 49.

- The date of service must be provided on the claim form for each service line submitted.

- Approved ADA dental codes as published in the current CDT manual or as defined in this manual must be used to define all services.

- List all quadrants, tooth numbers and surfaces for dental codes that necessitate identification (extractions, root canals, amalgams and resin fillings). Missing tooth and surface identification codes can result in the delay or denial of claim payment.

- Affix the proper postage when mailing bulk documentation. DentaQuest

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does not accept postage due mail. This mail will be returned to the sender and will result in delay of payment. Claims should be mailed to:

DentaQuest LLC
PO Box 2906
Milwaukee, WI 53201-2906
Or Fax to: 1-262-834-3589

4.07 Emergency Treatments and Authorizations

If a patient presents with an emergency condition that requires immediate treatment or intervention, you should always take necessary clinical steps to mitigate pain, swelling, or other symptoms that might put the member's overall health at risk and completely document your findings. After treatment, please complete the appropriate authorization request, and enter EMERGENCY/ URGENT in box 35, and the appropriate narrative or descriptor of the patient's conditions, including all supporting documentation.

Please FAX this to 262-241-7150.

DentaQuest will process emergency authorization requests as high priority. After you receive the authorization number, then and only then should you submit the claim. Our system will link the authorization number and the claim, and payment should be processed.

4.08 Coordination of Benefits

When DentaQuest is the secondary insurance carrier, a copy of the primary carrier's Explanation of Benefits (EOB) must be submitted with the claim. For electronic claim submissions, the payment made by the primary carrier must be indicated in the appropriate Coordination of Benefits (COB) field. When a primary carrier's payment meets or exceeds a Provider's contracted rate or fee schedule, DentaQuest will consider the claim paid in full and no further payment will be made on the claim.

4.09 Receipt and Audit of Claims

In order to ensure timely, accurate remittances to each participating provider, DentaQuest performs an audit of all claims upon receipt. This audit validates Member eligibility, procedure codes and Provider identifying information. A DentaQuest Benefit Analyst analyzes any claim conditions that would result in non-payment. When potential problems are identified, your office may be contacted and asked to assist in resolving this problem. Please contact our Customer Service Department with any questions you may have regarding claim submission or your remittance.

Each DentaQuest Provider office receives an Explanation of Benefit (EOB) report with their remittance. This report includes patient information and an allowable fee by date of service for each service rendered.

4.10 Payment for Non-Covered Services

Participating Providers agree to accept the DentaQuest payment as payment in full for benefit services. Texas law prohibits Providers from

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billing Texas Medicare Dental Program Members or the estates of deceased Members for benefit services.Participating Providers shall hold Members, DentaQuest and the Department harmless for the payment of non-Covered Services except as provided in this paragraph.

Member billing is prohibited for the following:

- The difference between the Participating Provider's charges and DentaQuest (i.e., Medicare), Medicare or commercial insurance payments. A covered service is defined as: A covered benefit as defined in the Covered Services Benefit Tables in the Texas GlobalHealth Medicare Advantage Office Reference Manual (ORM) Appendix B, Exhibits

- Participating Providers may not assert a lien on any money, settlement, recovery or judgment paid to the Member or to the Member's estate as the result of personal injury lawsuit.

- Constraints against billing Members for benefit services apply whether or not DentaQuest makes or has made payment and whether or not the Provider participates in the DentaQuest Provider Network.

- Participating Providers may not bill DentaQuest for missed appointments, telephone calls, completion of claim forms or medication refill approvals.

- Members may not be billed if the failure to obtain claim payment from DentaQuest is caused by the Participating Provider's failure to comply with the DentaQuest program
- billing procedures.

- Collections agencies cannot submit DentaQuest claims for payment and cannot collect payment from a Member.

Member billing is permitted when one of the following exists:

Participating Provider may bill a Member for Non-Covered Services if the Provider obtains a written acknowledgment of financial responsibility from the Member prior to rendering such services. A "Medicare Dental Non-Covered Services Disclosure Form" template is in Appendix A, under "Forms" as a resource for providers. The Participating Provider may only bill the Member if this form is completed and signed by the Member. Once the form is completed and signed, Members will have the following responsibilities:

- If the service is not a covered benefit, Members may be billed for the service. DentaQuest and Medicare encourage Participating Providers to bill Members at or near the current Medicare fee schedule amount.

- Some Members are responsible for a co-payment. By federal law, Participating Providers may not refuse services if the Member cannot pay a co-payment when services are rendered. Members may be billed for unpaid co-payments. Participating Providers may apply standard collection policies if the Member fails to satisfy copayment obligations.

- Members enrolled in DentaQuest must follow the DentaQuest rules. Members who insist upon obtaining care outside of the contracted network may be charged for non-

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covered services.

- Members who have commercial insurance coverage that requires them to obtain services through a Provider network must obtain all available services through the network. Members who insist upon obtaining managed care-covered services outside the network may be charged for such services.

4.11 Dispute Resolution/Provider Appeals Procedures and Timely Filing

Adverse action is any claim-specific action that does not result in authorized reimbursement for services rendered. The following are examples of adverse action:

- A claim rejection
- A claim denial
- A disputed payment on correspondence (including form letters) that identifies specific claims correspondence, reports, or forms that do not identify the Member, service date(s), types of service, and billing Provider are not recognized as proof of timely filing compliance. Prior authorization is not a timely filing waiver

Requests for Claims Reconsideration

The Provider must exhaust all rebilling and adjustment procedures before filing a Request for Claims Reconsideration.

- Requests for Claims Reconsideration must be filed in writing within 60 days of the last adverse action if initial timely filing has expired.

- Copies of all Explanation of Benefits (EOB) electronic claim rejections, and/or correspondence documenting compliance with timely filing and 60-day rule requirements must be submitted with the Request for Reconsideration.

Timely Filing

GlobalHealth Medicare Advantage dental claims must be filed with DentaQuest in a timely manner. A claim is considered to be filed when DentaQuest documents **receipt** of the claim.

- With few exceptions, electronic claims can be submitted 24 hours a day, seven days a week. Electronic claim receipt is documented by the assignment of a Claim
  Number. Electronic acceptance and rejection messages include the transaction date.

- Paper claim receipt is documented by DentaQuest's assignment of a Claim Number and captured in the received data field viewable on the Provider Web Portal (PWP).

- State holidays, weekends, and dates of business closure do not extend the timely filing period.

- Dated claim signatures, computerized or clerically prepared claim listings, and/or postmarks and certified mail receipts do not constitute proof of receipt for timely filing purposes.

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The Participating Provider is responsible for assuring that each claim is received within the timely filing period. With the exceptions of paper claims that are returned to the Participating Provider because of missing information and rejected electronic claims, all claims filed with DentaQuest appear on the Explanation of Benefits (EOB) as paid or denied within 30 days of receipt. If claim information does not appear on the EOB within 30 days of an electronic transmission or paper claim mailing, the Participating Provider is responsible for contacting DentaQuest to determine the status of the claim and **resubmitting the claim if necessary.**

Participating Providers can access the Provider Web Portal (PWP) to confirm whether DentaQuest has received a claim and the date it was recorded as received. In addition, the status of a claim (paid, denied or in process) is provided via the Provider Web Portal.

Agent or software failure to transmit accurate and acceptable claims or failure to identify transmission errors in a timely manner needs to be resolved between the Participating Provider and the agent or software vendor. Failure to comply with filing requirements (including timely filing) because of software product failure or the action (or inaction) of a billing agent are not recognized as extenuating circumstances beyond the Participating Provider's control.

Original Timely Filing

Timely filing for GlobalHealth Medicare Advantage Dental Program claim submission is **365 days from the date of service**. For dental services, the timely filing calculation is from the date of each service (line item).

Timely Filing Extensions for Circumstances Beyond the Provider’s Control

Occasionally, the timely filing period may expire because of delays in obtaining eligibility or third party processing information. The timely filing period may be extended under the following circumstances:

- Delayed Processing by Third Party Resources
- Delayed/Retroactive Member Eligibility
- Delayed Notification of Eligibility
- Other Circumstances beyond the Provider’s Control

Other Circumstances Beyond the Provider's Control

Reconsiderations that request timely filing waivers must contain a detailed description of the extenuating circumstances **beyond the Provider's control** resulting in failure to meet timely filing requirements.

Exceptions are granted only where the Participating Provider is able to document that appropriate action to meet filing requirements was taken and that the Participating Provider was prevented from filing as the result of exceptional circumstances that could not have been foreseen or controlled. Employee negligence, employer failure to provide sufficient, well-trained employees, or failure to properly monitor the activities of employees and agents (e.g., billing services) are not extenuating circumstances beyond the Participating Provider's control.

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Making false statements about timely filing compliance is a misrepresentation and falsification that, upon conviction, makes the individual who prepares the claim and the Participating Provider subject to fine and imprisonment under state and/or federal law. More information regarding Timely Filing is located in the Texas Medical Assistance Program CMS 1500 – General Provider Information and Requirements Manual.

Participating Providers that disagree with determinations made by the DentaQuest dental directors may submit a written Reconsideration to DentaQuest that specifies the nature and rationale of the disagreement. This notice and additional supporting information must be sent to DentaQuest within 60 days from the date of the original determination to be reconsidered by DentaQuest's Peer Review Committee at the following address:

DentaQuest
PO Box 2906
Milwaukee, WI 53201-2906
Attention: Utilization Management/Provider Appeals

All notices received shall be submitted to DentaQuest's Peer Review Committee for review and reconsideration. The Committee will respond in writing with its decision to the Participating Provider.

5.0 Filing Limits

Each provider contract specifies a specific timeframe after the date of service for when a claim must be submitted to DentaQuest. Any claim submitted beyond the timely filing limit specified in the contract will be denied for "untimely filing." If a claim is denied for "untimely filing", the provider cannot bill the member. If DentaQuest is the secondary carrier, the timely filing limit begins with the date of payment or denial from the primary carrier.

5.01 Receipt and Audit of Claims

In order to ensure timely, accurate remittances to each participating Provider, DentaQuest performs an audit of all claims upon receipt. This audit validates Member eligibility, procedure codes and dentist identifying information. A DentaQuest Benefit Analyst analyzes any claim conditions that would result in non-payment. When potential problems are identified, your office may be contacted and asked to assist in resolving this problem. Please contact our Customer Service Department with any questions you may have regarding claim submission or your remittance.

Each DentaQuest Provider office receives an "explanation of benefit" report with their remittance. This report includes patient information and an allowable fee by date of service for each service rendered.

5.02 Direct Deposit

As a benefit to participating Providers, DentaQuest offers Direct Deposit for claims payments. This process improves payment turnaround times as funds are directly deposited into the Provider's banking account.

To receive claims payments through the Direct Deposit Program, Providers must:

- Complete and sign the Direct Deposit Authorization Form at www.dentaquest.com.

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- Attach a voided check to the form. The authorization cannot be processed without a voided

- Return the Direct Deposit Authorization Form and voided check to DentaQuest.

    - Fax: **1-262-241-4077** or

    - Mail: **DentaQuest LLC**
      PO Box 2906
      Milwaukee, WI 53201-2906 ATTN: PDA Department

The Direct Deposit Authorization Form must be legible to prevent delays in processing. Providers should allow up to six weeks for the Direct Deposit Program to be implemented after the receipt of completed paperwork. Providers will receive a bank note one check cycle prior to the first Direct Deposit payment.

Providers enrolled in the Direct Deposit process must notify DentaQuest of any changes to bank accounts such as: changes in routing or account numbers, or a switch to a different bank. All changes must be submitted via the Direct Deposit Authorization Form. Changes to bank accounts or banking information typically take 2-3 weeks. DentaQuest is not responsible for delays in funding if Providers do not properly notify DentaQuest in writing of any banking changes.

Providers enrolled in the Direct Deposit Program are required to access their remittance statements online and will no longer receive paper remittance statements. Electronic remittance statements are located on DentaQuest's Provider Web Portal (PWP). Providers may access their remittance statements by following these steps:

1. Login to the PWP at www.dentaquest.com

2. Once you have entered the website, click on the "Dentist" icon. From there choose your 'State" and press go.

3. Log in using your password and ID

4. Once logged in, select "Claims/Pre-Authorizations" and then "Remittance Advice Search."

5. The remittance will display on the screen.

6.0 Health Insurance Portability and Accountability Act (HIPAA)

As a healthcare provider, your office is required to comply with all aspects of the HIPAA regulations in effect as indicated in the final publications of the various rules covered by HIPAA.

DentaQuest has implemented various operational policies and procedures to ensure that it is compliant with the Privacy, Administrative Simplification and Security Standards of HIIPAA. One aspect of our compliance plan is working cooperatively with our providers to comply with the HIPAA regulations. In relation to the Privacy Standards, DentaQuest has previously modified its provider contracts to reflect the appropriate HIPAA compliance language. These contractual updates include the following in regard to record handling and HIPAA requirements:

- Maintenance of adequate dental/medical, financial and administrative records related to covered dental services rendered by Provider in accordance with federal and state law.

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- Safeguarding of all information about Members according to applicable state and federal laws and regulations. All material and information, in particular information relating to Members or potential Members, which is provided to or obtained by or through a Provider, whether verbal, written, tape, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under state and feral laws.

- Neither DentaQuest nor Provider shall share confidential information with a Member's employer absent the Member's consent for such disclosure.

- Provider agrees to comply with the requirements of the Health Insurance Portability and Accountability Act ("HIPAA") relating to the exchange of information and shall cooperate with DentaQuest in its efforts to ensure compliance with the privacy regulations promulgated under HIPAA and other related privacy laws.

Provider and DentaQuest agree to conduct their respective activities in accordance with the applicable provisions of HIPAA and such implementing regulations.

In relation to the Administrative Simplification Standards, you will note that the benefit tables included in this ORM reflect the most current coding standards (CDT-4) recognized by the ADA. Effective the date of this manual, DentaQuest will require providers to submit all claims with the proper CDT-4 codes listed in this manual. In addition, all paper claims must be submitted on the current approved ADA claim form.

Note: Copies of DentaQuest's HIPAA policies are available upon request by contacting DentaQuest's Customer Service department at **1-800-936-0978** or via e-mail at **denelig.benefits@dentaquest.com.**

6.01 HIPAA Companion Guide

To view a copy of the most recent Companion Guide please visit our website at www.dentaquest.com. Once you have entered the website, click on the "Dentist" icon. From there choose your 'State" and press go. You will then be able to log in using your password and ID. Once you have logged in, click on the link named "Related Documents' (located under the picture on the right-hand side of the screen).

7.0 Quality Improvement Program (Policies 200 Series)

DentaQuest administers a Quality Improvement Program modeled after National Committee for Quality Assurance (NCQA) standards. The NCQA standards are adhered to as the standards apply to dental managed care. The Quality Improvement Program includes:

- Provider credentialing and recredentialing

- Member satisfaction surveys

- Provider satisfaction surveys

- Random Chart Audits

- Complaint Monitoring and Trending

- Peer Review Process

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- Utilization Management and practice patterns
- Initial Site Reviews and Dental Record Reviews; and
- Quarterly Quality Indicator tracking (i.e. member complaint rate, appointment waiting time, access to care, etc.)

A copy of DentaQuest's QI Program is available upon request by calling DentaQuest's Customer Service Department at **1-800-936-0978** or via e-mail at **denelig.benefits@dentaquest.com.**

8.0 Credentialing (Policies 300 Series)

DentaQuest in conjunction with the Plan has the sole right to determine which dentists (DDS or DMD) it shall accept and continue as Participating Providers. The purpose of the credentialing plan is to provide a general guide for the acceptance, discipline, and termination of participating providers. DentaQuest considers each Provider's potential contribution to the objective of providing effective and efficient dental services to Members of the Plan.

DentaQuest's credentialing process adheres to National Committee for Quality Assurance (NCQA) guidelines as the guidelines apply to dentistry.

Nothing in this Credentialing Plan limits DentaQuest's sole discretion to accept and discipline Participating Providers. No portion of this Credentialing Plan limits DentaQuest's right to permit restricted participation by a dental office or DentaQuest's ability to terminate a Provider's participation in accordance with the Participating Provider's written agreement, instead of this Credentialing Plan.

The Plan has the final decision-making power regarding network participation. DentaQuest will notify the Plan of all disciplinary actions enacted upon Participating Providers.

Appeal of Credentialing Committee Recommendations. (Policy 300.017)
If the Credentialing Committee recommends acceptance with restrictions or the denial of an application, the Committee will offer the applicant an opportunity to appeal the recommendation.

The applicant must request a reconsideration/appeal in writing and the request must be received by DentaQuest within 30 days of the date the Committee gave notice of its decision to the applicant.

Discipline of Providers (Policy 300.019)

Procedures for Discipline and Termination (Policies 300.017-300.021)

Recredentialing (Policy 300.016)
Network providers are recredentialed at least every 24 months.

The aforementioned policies are available upon request by contacting DentaQuest's Customer Service Department or via e-mail at **denelig.benefits@dentaquest.com**

9.0 The Patient Record

A. Organization

1. The record must have areas for documentation of the following information:

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a. Registration data including a complete health history.
b. Medical alert predominantly displayed inside the chart
c. Initial examination data.
d. Radiographs
e. Periodontal and Occlusal status.
f. Treatment plan/Alternative treatment plan.
g. Progress notes to include diagnosis, preventive services, treatment rendered, and medical/dental consultations.
h. Miscellaneous items (correspondence, referrals, and clinical laboratory reports).

2. The design of the record must provide the capability or periodic update, without the loss of documentation of the previous status, of the following information:

a. Health history.
b. Medical alert.
c. Examination/Recall data.
d. Periodontal status.
e. Treatment plan.

3. The design of the record must ensure that all permanent components of the record are attached or secured within the record.

4. The design of the record must ensure that all components must be readily identified to the patient (i.e., patient name, and identification number on each page).

5. The organization of the record system must require that individual records be assigned to each patient.

B. Content – The patient record must contain the following:

1. Adequate documentation of registration information that requires entry of these items:

a. Patient's first and last name.
b. Date of birth.
c. Sex.
d. Address.
e. Telephone number.
f. Name and telephone number of the person to contact in case of emergency.

2. An adequate health history that requires documentation of these items:

a. Current medical treatment.
b. Significant past illnesses.
c. Current medications.
d. Drug allergies.
e. Hematologic disorders
f. Cardiovascular disorders.
g. Respiratory disorders.
h. Endocrine disorders.
i. Communicable diseases.
j. Neurologic disorders.
k. Signature and date by patient.
l. Signature and date by reviewing dentist.
m. History of alcohol and/or tobacco usage including smokeless tobacco.

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3. An adequate update of health history at subsequent recall examinations that requires documentation of these items:

    a. Significant changes in health status.
    b. Current medical treatment.
    c. Current medications.
    d. Dental problems/concerns.
    e. Signature and date by reviewing dentist

4. A conspicuously placed medical alert inside the chart that documents highly significant terms from health history. These items are:

    a. Health problems that contraindicate certain types of dental treatment.
    b. Health problems that require precautions or pre-medication before dental treatment.
    c. Current medications that may contraindicate the use of certain types of drugs or dental treatment.
    d. Drug sensitivities.
    e. Infectious diseases that may endanger personnel or other patients.

5. Adequate documentation of the initial clinical examination that is dated and requires descriptions of findings in these items:

    a. Blood pressure. (Recommended)
    b. Head/neck examination.
    c. Soft tissue examination.
    d. Periodontal assessment.
    e. Occlusal classification.
    f. Dentition charting.

6. Adequate documentation of the patient's status at subsequent Periodic/Recall examinations that is dated and requires descriptions of changes/new findings in these items:

    a. Blood pressure. (Recommended)
    b. Head/neck examination.
    c. Soft tissue examination.
    d. Periodontal assessment.
    e. Dentition charting.

7. Radiographs which are:

    a. Identified by patient name.
    b. Dated.
    c. Designated by patient's left and right side.
    d. Mounted (if intraoral films).

8. An indication of the patient's clinical problems/diagnosis.

9. Adequate documentation of the treatment plan (including any alternate treatment options) that specifically describes all the services planned for the patient by entry of these items:

    a. Procedure.
    b. Localization (area of mouth, tooth number, surface).

10. An adequate documentation of the periodontal status, if necessary, which is dated and requires charting of the location and severity of these items:

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a. Periodontal pocket depth.
b. Furcation involvement.
c. Mobility.
d. Recession.
e. Adequacy of attached gingiva.
f. Missing teeth.

11. An adequate documentation of the patient's oral hygiene status and preventive efforts which requires entry of these items:

    a. Gingival status.
    b. Amount of plaque.
    c. Amount of calculus.
    d. Education provided to the patient.
    e. Patient receptiveness/compliance.
    f. Recall interval.
    g. Date.

12. An adequate documentation of medical and dental consultations within and outside the practice which requires entry of these items:

    a. Provider to whom consultation is directed.
    b. Information/services requested.
    c. Consultant's response.

13. Adequate documentation of treatment rendered which requires entry of these items:

    a. Date of service/procedure.
    b. Description of service, procedure, and observation. Documentation in treatment record must contain documentation to support the level of American Dental Association Current Dental Terminology code billed as detailed in the nomenclature and descriptors. Documentation must be written on a tooth by tooth basis for a per tooth code, on a quadrant basis for a quadrant code and on a per arch basis for an arch code.
    c. Type and dosage of anesthetics and medications given or prescribed.
    d. Localization of procedure/observation. (tooth number, quadrant etc.)
    e. Signature of the Provider who rendered the service.

14. Adequate documentation of the specialty care performed by another dentist that includes:

    a. Patient examination.
    b. Treatment plan.
    c. Treatment status.

C. Compliance

1. The patient record has one explicitly defined format that is currently in use.

2. There is consistent use of each component of the patient record by all staff.

3. The components of the record that are required for complete documentation of each patient's status and care are present.

4. Entries in the records are legible.

5. Entries of symbols and abbreviations in the records are uniform, easily interpreted and are commonly understood in the practice.

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10.0 Patient Recall System Requirements

A. Recall System Requirement

Each participating DentaQuest office is required to maintain and document a formal system for patient recall. The system can utilize either written or phone contact. Any system should encompass routine patient check-ups, cleaning appointments, follow-up treatment appointments, and missed appointments for any Health Plan enrollee that has sought dental treatment.

If a written process is utilized, the following language is suggested for missed appointments:

- "We missed you when you did not come for your dental appointment on month/date. Regular check-ups are needed to keep your teeth healthy."
- "Please call to reschedule another appointment. Call us ahead of time if you cannot keep the appointment. Missed appointments are very costly to us. Thank you for your help."

Dental offices indicate that Medicare patients sometimes fail to show up for appointments. DentaQuest offers the following suggestions to decrease the "no show" rate.

- Contact the Member by phone or postcard prior to the appointment to remind the individual of the time and place of the appointment.
- If the appointment is made through a government supported screening program, contact staff from these programs to ensure that scheduled appointments are kept.

B. Office Compliance Verification Procedures

- In conjunction with its office claim audits described in section 4, DentaQuest will measure compliance with the requirement to maintain a patient recall system.
- DentaQuest Dentists are expected to meet minimum standards with regards to appointment availability.
- Emergency and urgent care must be available within 24 hours.
- Routine care must be available within 30 days

Follow-up appointments must be scheduled within 30 days of the present treatment date, as appropriate.

11.0 Radiology Requirements

Note: Please refer to benefit tables for radiograph benefit limitations.

DentaQuest utilizes the guidelines published by the Department of Health and Human Services, Center for Devices and Radiological Health. These guidelines were developed in conjunction with the Food and Drug Administration.

A. Radiographic Examination of the New Patient

1. Adult – dentulous

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The Panel recommends an individualized radiographic examination consisting of selected periapicals with posterior bitewings for a new dentulous adult patient.

2. Adult – edentulous

   The Panel recommends a full-mouth intraoral radiographic survey OR a panoramic radiograph for the new edentulous adult patient.

B. Radiographic Examination of the Recall Patient

1. Patients with clinical caries or other high – risk factors for caries

   a. Adult – dentulous

      The Panel recommends that posterior bitewings be performed at a 6-12 month interval for adults with clinical caries or who are at increased risk for the development of caries.

   b. Adult – edentulous

      The Panel found that an examination for occult disease in this group cannot be justified on the basis of prevalence, morbidity, mortality, radiation dose and cost. Therefore, the Panel recommends that no radiographs be performed for edentulous recall patients without clinical signs or symptoms.

2. Patients with no clinical caries and no other high-risk factors for caries

   a. Adult – dentulous

      The Panel recommends that posterior bitewings be performed at intervals of 24-36 months for dentulous adult patients who show no clinical caries and are not at an increased risk for the development of caries.

3. Patients with periodontal disease, or a history of periodontal treatment for child – primary and transitional dentition, adolescent and dentulous adult

   The Panel recommends an individualized radiographic survey consisting of selected periapicals and/or bitewing radiographs of areas with clinical evidence or a history of periodontal disease (except nonspecific gingivitis).

4. Growth and Development Assessment

   a. Adult

      The Panel recommends that no radiographs be performed on adults to assess growth and development in the absence of clinical signs or symptoms.

12.0 Clinical Criteria

The criteria outlined in DentaQuest's Provider Office Reference Manual are based around procedure codes as defined in the American Dental Association's Code Manuals. Documentation requests for information regarding treatment using these codes are determined by generally accepted dental standards for authorization, such as radiographs, periodontal charting, treatment plans, or descriptive narratives. In some instances, the State legislature will define the requirements for dental procedures.

These criteria were formulated from information gathered from practicing dentists, dental schools,

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ADA clinical articles and guidelines, insurance companies, as well as other dental related organizations. These criteria and policies must meet and satisfy specific State and Health Plan requirements as well. They are designed as guidelines for authorization and payment decisions and are not intended to be all-inclusive or absolute. Additional narrative information is appreciated when there may be a special situation.

We hope that the enclosed criteria will provide a better understanding of the decision-making process for reviews. We also recognize that “local community standards of care” may vary from region to region and will continue our goal of incorporating generally accepted criteria that will be consistent with both the concept of local community standards and the current ADA concept of national community standards. Your feedback and input regarding the constant evolution of these criteria is both essential and welcome. DentaQuest shares your commitment and belief to provide quality care to Members and we appreciate your participation in the program.

Please remember these are generalized criteria. Services described may not be covered in your particular program. In addition, there may be additional program specific criteria regarding treatment. Therefore, it is essential you review the Benefits Covered Section before providing any treatment.

These clinical criteria will be used for making medical necessity determinations for prior authorizations, post payment review and retrospective review. Failure to submit the required documentation may result in a disallowed request and/or a denied payment of a claim related to that request. Some services require prior authorization and some services require pre-payment review. This is detailed in the Benefits Covered Section(s) in the “Review Required” column.

For all procedures, every Provider in the DentaQuest program is subject to random chart audits. Providers are required to comply with any request for records.
These audits may occur in the Provider’s office as well as in the office of DentaQuest. The Provider will be notified in writing of the results and findings of the audit.

DentaQuest providers are required to maintain comprehensive treatment records that meet professional standards for risk management. Please refer to the “Patient Record” section for additional detail.

Documentation in the treatment record must justify the need for the procedure performed due to medical necessity, for all procedures rendered. Appropriate diagnostic pre-operative radiographs clearly showing the adjacent and opposing teeth and substantiating any pathology or caries present are required. Post-operative radiographs are required for endodontic procedures and permanent crown placement to confirm quality of care. In the event that radiographs are not available or cannot be obtained, diagnostic quality intraoral photographs must substantiate the need for procedures rendered.

Multistage procedures are reported and may be reimbursed upon completion. The completion date is the date of insertion for removable prosthetic appliances. The completion date for immediate dentures is the date that the remaining teeth are removed, and the denture is inserted. The completion date for fixed partial dentures and crowns, onlays, and inlays is the cementation date regardless of the type of cement utilized. The completion date for endodontic treatment is the date the canals are permanently filled.

Failure to provide the required documentation, adverse audit findings, or the failure to maintain acceptable practice standards may result in sanctions including, but not limited to, recoupment of benefits on paid claims follow-up audits, or removal of the Provider from the DentaQuest Provider Panel.

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12.01 Criteria for Medical Immobilization (Including Restraint Boards)

Written informed consent from a legal guardian must be obtained and documented in the patient record prior to medical immobilization.

The patient's record should include:

- Informed consent
- Type of immobilization used
- Indication for immobilization
- The duration of application

Indications*:

- patient who requires immediate diagnosis and/ or limited treatment and cannot cooperate due to lack of maturity
- patient who requires immediate diagnosis and/ or limited treatment and cannot cooperate due to a mental or physical disability
- when the safety of the patient and/ or practitioner would be at risk without the protective use of immobilization.

Contraindications*:

- cooperative patient
- patient who cannot be immobilized safely due to associated medical conditions.

Goals of Behavior Management*:

- establish communication
- alleviate fear and anxiety
- deliver quality dental care
- build a trusting relationship between dentist and child
- promote the child's positive attitude towards oral/ dental health

1. **Routine use of restraining devices to immobilize young children in order to complete their dental care is not acceptable practice, violates the standard of care, and will result in termination of the provider from the network.**
2. **Dentists should not restrain children without formal training at a dental school or approved residency program.**

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3. **Dentists should consider referring to specialists those patients who they consider to be candidates for immobilization.**

4. **Dental auxiliaries should not use restraining devices to immobilize children.**

*American Academy of Pediatric Dentistry. Guideline on behavior management. Reference Manual 2002-2003.

12.02 Criteria for Dental Extractions

Dental adheres to the following policy for evaluating removal of teeth in order to maintain consistency throughout its dental networks.

Documentation needed for authorization procedure:

- Panorex: bitewing radiographs or periapical radiographs showing the entire tooth (teeth) to be extracted as well as opposing teeth
- Tooth specific narrative demonstrating medical necessity
    - A decision regarding benefits is made on the basis of the documentation provided.
    - Treatment rendered without necessary pre-authorization is subject to retrospective review.

Codes: DentaQuest adheres to the code definitions as described in the American Dental Association Current Dental Terminology User's Manual.

Criteria:

- The prophylactic removal of asymptomatic teeth or teeth exhibiting no overt clinical pathology is not a covered benefit.

- The removal of primary teeth whose exfoliation is imminent is not a covered benefit.

- In most cases, extractions that render a patient edentulous must be deferred until authorization to construct a denture has been given.

- Alveoloplasty (code D7310) in conjunction with a surgical extraction in the same quadrant is not a covered benefit.

- Extractions performed as a part of a course of orthodontics are covered only if the orthodontic case is a covered benefit.

- The extraction of primary or permanent teeth does not require authorization unless:

- The extraction of primary or permanent teeth does not require authorization unless:

    - Teeth are impacted wisdom teeth

    - Residual roots requiring surgical removal

    - Surgical extraction of erupted teeth.

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- Removal of primary teeth whose exfoliation is imminent does not meet criteria for extraction.

Documentation needed for authorization procedure:

- Diagnostic-quality periapical and/or panoramic radiographs
- Radiographs must be mounted, contain the patient name and the date the radiographs were taken, not the date of submission
- Duplicate radiographs must be labeled Right (R) and Left (L), include the patient name and the date the radiograph(s) were taken, not the date of submission.
- Extraction of impacted wisdom teeth or surgical removal of residual tooth roots will require a written narrative of medical necessity that is tooth specific.

Authorization for extraction of impacted third molars:

- Benefit review decisions for authorization of the extraction of impacted third molar
- teeth will be based upon medical necessity and upon appropriate code utilization for
- the current ADA codes D7220, D7230, D7240, and D7241. Benefit review decisions
- for authorization of the extraction of impacted third molar teeth are tooth specific.
- The prophylactic removal of disease-free third molars is not covered.
- Impacted third molars that do not show pathology will not qualify for an authorization for extraction.
- Impacted third molars that do not demonstrate radiographic aberrant tooth position beyond normal variations will not qualify for an authorization for extraction.
- Normal eruption discomfort and localized inflammatory conditions will not qualify impactions for an authorization for extraction.
- Lack of eruptive space will not qualify for an authorization for extraction of impacted third molars.

Reference: American Association of Oral Maxillofacial Surgeons and American Dental Association

12.03 Criteria for Cast Crowns

Documentation needed for authorization of procedure:

- Appropriate radiographs showing clearly the adjacent and opposing teeth should be submitted for authorization review: bitewings, periapicals or panorex.

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- Treatment rendered without necessary authorization will still require that sufficient and appropriate radiographs showing clearly the adjacent and opposing teeth be submitted with the claim for review for payment.

Criteria:

- In general, criteria for crowns will be met only for permanent teeth needing multi-surface restorations where other restorative materials have a poor prognosis.
- Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma and should involve four or more surfaces and two or more cusps.
- Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma and should involve three or more surfaces and at least one cusp.
- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma and must involve four or more surfaces and at least 50% of the incisal edge.
- A request for a crown following root canal therapy must meet the following criteria:
    - Request should include a dated post-endodontic radiograph.
    - Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the ability to fill the canal to the apex.
    - The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.
- To meet criteria, a crown must be opposed by a tooth or denture in the opposite arch or be an abutment for a partial denture.
- The patient must be free from active and advanced periodontal disease.
- The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.
- Cast Crowns on permanent teeth are expected to last, at a minimum, five years.
- Authorizations for Crowns will not meet criteria if:
    - A lesser means of restoration is possible.
    - Tooth has subosseous and/or furcation caries.
    - Tooth has advanced periodontal disease
    - Tooth is a primary tooth.
    - Crowns are being planned to alter vertical dimension.

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12.04 Criteria for periodontal Treatment

Documentation needed for authorization of procedure:

- Radiographs – periapicals or bitewings preferred.
- Complete periodontal charting with AAP Case Type.
- Treatment plan.

Periodontal scaling and root planing, per quadrant involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and as a part of pre-surgical procedures in others.

It is anticipated that this procedure would be requested in cases of severe periodontal conditions (i.e. late Type II, III, IV periodontitis) where definitive comprehensive root planing requiring local/regional block anesthesia and several appointments would be indicated.

From the American Academy of Periodontology (AAP) Policy on Scaling and Root Planing:

“Periodontal scaling is a treatment procedure involving instrumentation of the crown and root surfaces of the teeth to remove plaque, calculus, and stains from these surfaces. It is performed on patients with periodontal disease and is therapeutic, not prophylactic, in nature. Periodontal scaling may precede root planing, which is the definitive, meticulous treatment procedure to remove cementum and/or dentin that is rough and may be permeated by calculus or contaminated with toxins or microorganisms. Periodontal scaling and root planing are arduous and time consuming. They may need to be repeated and may require local anesthetic.”

Criteria

- A minimum of four (4) teeth affected in the quadrant.
- Periodontal charting indicating abnormal pocket depths in multiple sites.
- Additionally, at least one of the following must be present:
    1. Radiographic evidence of root surface calculus.
    2. Radiographic evidence of noticeable loss of bone support.

12.05 Criteria for Endodontics

Not all procedures require authorization.

Documentation needed for authorization of procedure:

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- Sufficient and appropriate radiographs clearly showing the adjacent and opposing teeth and a pre-operative radiograph of the tooth to be treated; bitewings, periapicals or panorex. A dated post-operative radiograph must be submitted for review for payment.

- Treatment rendered under emergency conditions, when authorization is not possible, will still require that appropriate radiographs clearly showing the adjacent and opposing teeth, pre-operative radiograph and dated post-operative radiograph of the tooth treated with the claim for retrospective review for payment. In cases where pathology is not apparent, a written narrative justifying treatment is required.

Criteria:

Root canal therapy is performed in order to maintain teeth that have been damaged through trauma or carious exposure.

Root canal therapy must meet the following criteria:

- Fill should be sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex.

- Fill must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

Authorizations for Root Canal therapy will not meet criteria if:

- Gross periapical or periodontal pathosis is demonstrated radiographically (caries subcrestal or to the furcation, deeming the tooth non-restorable).

- The general oral condition does not justify root canal therapy due to loss of arch integrity.

- Root canal therapy is for third molars, unless they are an abutment for a partial

- denture.

- Tooth does not demonstrate 50% bone support.

- Root canal therapy is in anticipation of placement of an overdenture.

- A filling material not accepted by the Federal Food and Drug Administration (e.g. Sargenti filling material) is used.

Other Considerations:

- Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canal(s), and progress radiographs, including a root canal fill radiograph.

- In cases where the root canal filling does not meet DentaQuest's treatment standards, DentaQuest can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after DentaQuest reviews the circumstances.

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12.06 Criteria for Stainless Steel Crowns

Although authorization for Stainless Steel Crowns is not required, documentation justifying the need for treatment using Stainless Steel Crowns must be made available upon request for review by DentaQuest pre-operatively or post-operatively and include the following:

- Appropriate diagnostic radiographs clearly showing the adjacent and opposing

  teeth and pathology or caries-detecting intra-oral photographs if radiographs could not be made.

- Copy of patient's dental record with complete caries charting and dental anomalies

- Copy of detailed treatment plan. Note: Failure to submit the required documentation if requested may result in the recoupment of benefits on a paid claim.

Criteria:

- In general, criteria for stainless steel crowns will be met only for teeth needing multi surface restorations or where amalgams, composites, and other restorative materials have a poor prognosis.

- Permanent molar teeth should have pathologic destruction to the tooth by caries or trauma and should involve four or more surfaces and/or two or more cusps.

- Permanent bicuspid teeth should have pathologic destruction to the tooth by caries or trauma and should involve three or more surfaces and at least one cusp.

- Permanent anterior teeth should have pathologic destruction to the tooth by caries or trauma and should involve four or more surfaces and at least 50% of the incisal edge.

- Primary anterior teeth should have pathologic destruction to the tooth by caries or trauma and should involve two or more surfaces or incisal decay resulting in an enamel shell.

- Primary molars should have pathologic destruction to the tooth by caries or trauma and should involve two or more surfaces or substantial occlusal decay resulting in an enamel shell.

- Primary teeth that have had a pulpotomy or pulpectomy performed.

    - Note: DentaQuest may require a second opinion for requests of more than 4 stainless steel crowns per patient.

An authorization for a crown on a permanent tooth following root canal therapy must meet the following criteria:

- Claim should include a dated post-endodontic radiograph.

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- Tooth should be filled sufficiently close to the radiological apex to ensure that an
- apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex.
- The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

To meet criteria, a crown must be opposed by a tooth or denture in the opposite arch or be an abutment for a partial denture.

- The patient must be free from active and advanced periodontal disease.
- The permanent tooth must be at least 50% supported in bone.
- Stainless steel crowns on permanent teeth are expected to last five years.

Criteria for treatment using stainless steel crowns will not be met if:

- A lesser means of restoration is possible.
- Tooth has subosseous and/or furcation caries.
- Tooth has advanced periodontal disease.
- Member is age 6 or older and tooth is a primary tooth with exfoliation imminent.
- Crowns are being planned to alter vertical dimension.
- Tooth has no apparent pathologic destruction due to caries or trauma.

12.07 Criteria for Removable Prosthodontics (Full and Partial Dentures)

Documentation needed for authorization of procedure:

- Treatment plan.
- Appropriate radiographs clearly showing the adjacent and opposing teeth must be submitted for authorization review: bitewings, periapicals or panorex.
- Treatment rendered without necessary authorization will still require appropriate radiographs clearly showing the adjacent and opposing teeth be submitted with the claim for review for payment.
- Fabrication of a removable prosthetic includes multiple steps(appointments) these multiple steps (impressions, try-in appointments, delivery etc.) are inclusive in the fee for the removable prosthetic and as such not eligible for additional compensation.

Criteria:

Prosthetic services are intended to restore oral form and function due to premature loss

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of permanent teeth that would result in significant occlusal dysfunction.

- A denture is determined to be an initial placement if the patient has never worn prosthesis. This does not refer to just the time a patient has been receiving treatment from a certain Provider.
- Partial dentures are covered only for recipients with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.
- Radiographs must show no untreated cavities or active periodontal disease in the abutment teeth, and abutments must be at least 50% supported in bone.
- As part of any removable prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis.
- In general, if there is a pre-existing removable prosthesis (includes partial and full dentures), it must be at least 5 years old and unserviceable to qualify for replacement.
- The replacement teeth should be anatomically full-sized teeth.

Authorizations for Removable prosthesis will not meet criteria:

- If there is a pre-existing prosthesis which is not at least 5 years old and unserviceable.
- If good oral health and hygiene, good periodontal health, and a favorable prognosis are not present.
- If there are untreated cavities or active periodontal disease in the abutment teeth.
- If abutment teeth are less than 50% supported in bone.
- If the recipient cannot accommodate and properly maintain the prosthesis (i.e.. Gag reflex, potential for swallowing the prosthesis, severely handicapped) If the recipient has a history or an inability to wear a prosthesis due to psychological or physiological reasons.
- If a partial denture, less than five years old, is converted to a temporary or permanent complete denture.
- If extensive repairs are performed on marginally functional partial dentures, or when a new partial denture would be better for the health of the recipient. However, adding teeth and/or a clasp to a partial denture is a covered benefit if the addition makes the denture functional.

Criteria:

- If there is a pre-existing prosthesis, it must be at least 5 years old and unserviceable to qualify for replacement.
- Adjustments, repairs and relines are included with the denture fee within the first

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6 months after insertion. After that time has elapsed:

- Adjustments will be reimbursed at one per calendar year per denture.
- Repairs will be reimbursed at two repairs per denture per year, with five total denture repairs per 5 years
- Relines will be reimbursed once per denture every 36 months.
- A new prosthesis will not be reimbursed for within 24 months of reline or repair of the existing prosthesis unless adequate documentation has been presented that all procedures to render the denture serviceable have been exhausted.
- Replacement of lost, stolen, or broken dentures less than 5 years of age usually will not meet criteria for pre-authorization of a new denture.
- The use of Preformed Dentures with teeth already mounted (that is, teeth set in acrylic before the initial impression) cannot be used for the fabrication of a new denture.
- All prosthetic appliances shall be inserted in the mouth and adjusted before a claim is submitted for payment.
- When billing for partial and complete dentures, dentists must list the date that the dentures or partials were inserted as the date of service. Recipients must be eligible on that date in order for the denture service to be covered.

12.08 Criteria for Fixed Prosthodontics

Documentation needed for authorization of procedure:

- Appropriate radiographs clearly showing the adjacent and opposing teeth should be submitted for authorization review: bitewings, periapicals or panorex
- Treatment rendered without necessary authorization will still require that sufficient and appropriate radiographs clearly showing the adjacent and opposing teeth be submitted with the claim for review for payment.
- The placement of a fixed prosthetic appliance will only be considered for those exceptional cases where there is a documented physical or neurological disorder that would preclude placement of a removable prosthesis.
- Prosthetic services are intended to restore oral form and function due to premature loss of permanent teeth that would result in significant occlusal dysfunction.
- Fixed Partial dentures are covered only for recipients with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.

As part of any fixed prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis. When billing for fixed partial dentures, dentists must list the date of insertion as the date of service. Recipients must be eligible on that date for

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the denture service to be covered.

Authorizations for prosthesis do not meet criteria:

- If appropriate documentation is not received documenting physical or neurological disorders precluding the placement of a removable prosthesis.
- If good oral health and hygiene, good periodontal health, and a favorable prognosis are not present.
- If abutment teeth are less than 50% supported in bone.
- If there are untreated cavities or active periodontal disease in the abutment teeth.

12.09 Criteria for the Excision of Bone Tissue

To ensure the proper seating of a removable prosthetic (partial or full denture) some treatment plans may require the removal of excess bone tissue prior to the fabrication of the prosthesis. Clinical guidelines have been formulated for the dental consultant to ensure that the removal of tori (mandibular and palatal) is an appropriate course of treatment prior to prosthetic treatment.

Code D7471 (CDT–4) is related to the removal of the lateral exostosis. This code is subject to authorization and may be reimbursed for when submitted in conjunction with a treatment plan that includes removable prosthetics. These determinations will be made by the appropriate dental specialist/consultant.

Documentation needed for authorization of procedure:

- Appropriate radiographs and/or intraoral photographs/bone scans which clearly identify the lateral exostosis must be submitted for authorization review; bitewings, periapicals or panorex.
- Treatment plan – includes prosthetic plan.
- Narrative of medical necessity, if appropriate.
- Study model or photo clearly identifying the lateral exostosis (es) to be removed

12.10 Criteria for the Determination of a Non-Restorable Tooth

In the application of clinical criteria for benefit determination, dental consultants must consider the overall dental health. A tooth that is determined to be non-restorable may be subject to an alternative treatment plan.

- A tooth may be deemed non-restorable if one or more of the following criteria are present:
- The tooth presents with greater than a 75% loss of the clinical crown.
- The tooth has less than 50% bone support.
- The tooth has subosseous and/or furcation caries.

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- The tooth is a primary tooth with exfoliation imminent.
- The tooth apex is surrounded by severe pathologic destruction of the bone.
- The overall dental condition (i.e. periodontal) of the patient is such that an alternative treatment plan would be better suited to meet the patient's needs.

12.11 Cultural Competency Program

DentaQuest incorporates measures to promote cultural sensitivity/awareness in the delivery of Member services as well as healthcare services. Services to Members are delivered in a manner sensitive to the Member's cultural background and his/her religious beliefs, values and traditions. It is the policy of DentaQuest to provide Medicare, Medicaid, Commercial and DentaQuest employee information in a culturally competent manner that assists all individuals, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds or physical or mental disabilities issues in obtaining health care services. DentaQuest incorporates measures to track bias/discrimination issues that hinder or prevent to be administered in accordance with the American with Disabilities Act, and other applicable Federal and State laws, to its members and DentaQuest employees and report appropriate occurrences to the Complaint and Grievance Department or Human Resources Department.

DentaQuest ensures that its staff is trained in cultural awareness to provide a competent system of services, which acknowledges and incorporates the importance of culture, language, and the values and traditions of members.

DentaQuest ensures that its staff is trained in cultural awareness to provide a competent system of services, which acknowledges and incorporates the importance of culture, language, and the values and traditions of all DentaQuest's employees.

DentaQuest supports Providers in efforts to work in a cross-cultural environment and to ensure the adaptation of services to meet Members cultural and linguistic needs.

A copy of DentaQuest's Cultural Competency Plan is available at no charge upon request by contacting DentaQuest's Customer Service Department or via e- mail at **denelig.benfits@dentaquest.com.**

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Appendix A

Attachments

General Definitions

The following definitions apply to this Office Reference Manual:

A. “Contract” means the document specifying the services provided by DentaQuest to:

- An employer, directly or on behalf of GlobalHealth Medicare Advantage, as agreed upon between an employer or Plan and DentaQuest (a “Commercial Contract”);
- A Medicare beneficiary, directly or on behalf of a Plan, as agreed upon between the State of Texas or its regulatory agencies or Plan and DentaQuest (a “Medicare Contract”);
- A Medicare beneficiary, directly or on behalf of a Plan, as agreed upon between the Center for Medicare Services (“CMS”) or Plan and DentaQuest (a “Medicare Contract”).

B. “Covered Services” is a dental service or supply that satisfies all of the following criteria:

- Provided or arranged by a Participating Provider to a member;
- Authorized by DentaQuest in accordance with the Plan Certificate; and
- Submitted to DentaQuest according to DentaQuest’s filing requirements.

C. “DentaQuest” shall refer to GlobalHealth.

D. "DentaQuest Service Area" shall be defined by GlobalHealth.

E. “Medically Necessary:” It is the responsibility of the health plan to determine whether or not a service(s) furnished or proposed to be furnished is (are) reasonable and medically necessary for the diagnosis or treatment of illness or injury, to improve the function of a malformed body member, or to minimize the progression of disability, in accordance with accepted standards of practice in the medical community of the area in which the health services are rendered; and service(s) could not have been omitted without adversely affecting the member’s condition or the quality of medical care rendered; and service(s) is (are) furnished in the most appropriate setting.

F. “Member” means any individual who is eligible to receive Covered Services pursuant to a Contract and the eligible dependents of such individuals. A Member enrolled pursuant to a Commercial Contract is referred to as a “Commercial Member.” A Member enrolled pursuant to a Medicare Contract is referred to as a “Medicare Member.” A Member enrolled pursuant to a Medicare Contract is referred to as a “Medicare Member.”

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G. “Participating Provider” is a dental professional or facility or other entity, including a Provider that has entered into a written agreement with DentaQuest, directly or through another entity, to provide dental services to selected groups of Members.

H. “Plan” is an insurer, health maintenance organization or any other entity that is an organized system which combines the delivery and financing of health care and which provides basic health services to enrolled Members for a fixed prepaid fee.

I. “Plan Certificate” means the document that outlines the benefits available to Members.

J. "Provider" means the undersigned health professional or any other entity that has entered into a written agreement with DentaQuest to provide certain health services to Members. Each Provider shall have its own distinct tax identification number.

K. “Provider Dentist” is a Doctor of dentistry, duly licensed and qualified under the applicable laws, who practices as a shareholder, partner, or employee of Provider, and who has executed a Provider Dentist Participation Addendum

Additional Resources
Welcome to the DentaQuest provider forms and attachment resource page. The links below provide methods to access and acquire both electronic and printable forms addressed within this document. To view copies, please visit www.dentaquest.com. Once you have entered the website, click on the “Dentist” icon. From there choose your State and press go. You will then log in with your User ID and passwordID. Once logged in, select the link “Related Documents” to access the following resources:

- ADA Dental Claim Form
- Instructions for Dental Claim Form
- Initial Clinical Exam Form
- Recall Examination Form
- Authorization for Dental Treatment
- Direct Deposit Form
- Medical and Dental History
- Provider Change Form
- Request for Transfer of Records
- HIPAA Companion Guide

You can also find the forms within this manual.

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) A _____ C _____
(Primary diagnosis in "**A**") B _____ D _____

31a. Other Fee(s)
32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) - | 52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

57. Phone Number ( ) - | 58. Additional Provider ID

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J430D (Same as ADA Dental Claim Form – J430, J431, J432, J433, J434)

To reorder call 800.947.4746 or go online at adacatalog.org

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ADA American Dental Association®
America's leading advocate for oral health

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are printed in the CDT manual. Any updates to these instructions will be posted on the ADA's web site (ADA.org).

GENERAL INSTRUCTIONS

A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 window envelope (window to the left). Please fold the form using the 'tick-marks' printed in the margin.

B. Complete all items unless noted otherwise on the form or in the CDT manual's instructions.

C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.

D. All dates must include the four-digit year.

E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the "Remarks" field (Item 35). There are additional detailed completion instructions in the CDT manual.

DIAGNOSIS CODING

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)

Item 34 – Diagnosis Code List Qualifier (B for ICD-9-CM; AB for ICD-10-CM)

Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter "A")

PLACE OF TREATMENT

Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

The full list is available online at "www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf"

PROVIDER SPECIALTY

This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

Category / Description Code	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Provider taxonomy codes listed above are a subset of the full code set that is posted at "www.wpc-edi.com/codes/taxonomy"

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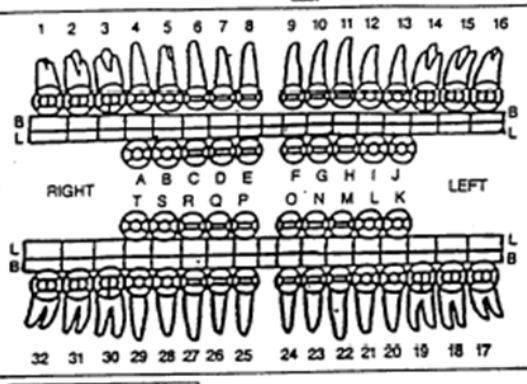
ALLERGY	PRE MED	MEDICAL ALERT

INITIAL CLINICAL EXAM

PATIENT'S NAME _____ Last First Middle



GINGIVA

MOBILITY

PROTHESIS EVALUATION

OCCLUSION I II III

PATIENT'S CHIEF COMPLAINT

	OK
LYMPH NODES	
PHARYNX	
TONSILS	
SOFT PALATE	
HARD PALATE	
FLOOR OF MOUTH	
TONGUE	
VESTIBULES	
BUCCAL MUCOSA	
LIPS	
SKIN	
TMJ	
ORAL HYGIENE	
PERIO EXAM	

CLINICAL FINDINGS/COMMENTS

RADIOGRAPHS	B/P	RDH/DDS

RECOMMENDED TREATMENT PLAN

TOOTH OR AREA	DIAGNOSIS	PLAN A	PLAN B

SIGNATURE OF DENTIST DATE

Note: The above form is intended to be a sample. DentaQuest is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.

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RECALL EXAMINATION

PATIENT'S NAME _____

CHANGES IN HEALTH STATUS/MEDICAL HISTORY _____

	OK		OK	CLINICAL FINDINGS/COMMENTS
LYMPH NODES		TMJ		
PHARYNX		TONGUE		
TONSILS		VESTIBULES		
SOFT PALATE		BUCCAL MUCOSA		
HARD PALATE		GINGIVA		
FLOOR OF MOUTH		PROSTHESIS		
LIPS		PERIO EXAM		
SKIN		ORAL HYGIENE		
RADIOGRAPHS		B/P		RDH/DDS

R **WORK NECESSARY** **L**

TOOTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
SERVICE																
TOOTH	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
SERVICE																

COMMENTS: _____

RECALL EXAMINATION

PATIENT'S NAME _____

CHANGES IN HEALTH STATUS/MEDICAL HISTORY _____

	OK		OK	CLINICAL FINDINGS/COMMENTS
LYMPH NODES		TMJ		
PHARYNX		TONGUE		
TONSILS		VESTIBULES		
SOFT PALATE		BUCCAL MUCOSA		
HARD PALATE		GINGIVA		
FLOOR OF MOUTH		PROSTHESIS		
LIPS		PERIO EXAM		
SKIN		ORAL HYGIENE		
RADIOGRAPHS		B/P		RDH/DDS

R **WORK NECESSARY** **L**

TOOTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
SERVICE																
TOOTH	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
SERVICE																

COMMENTS: _____

NOTE: The above form is intended to be a sample. DentaQuest is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.

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Authorization for Dental Treatment

I hereby authorize Dr._____and his/her associates to provide dental services, prescribe, dispense and/or administer any drugs, medicaments, antibiotics, and local anesthetics that he/she or his/her associates deem, in their professional judgement, necessary or appropriate in my care.

I am informed and fully understand that there are inherent risks involved in the administration of any drug, medicament, antibiotic, or local anesthetic. I am informed and fully understand that there are inherent risks involved in any dental treatment and extractions (tooth removal). The most common risks can include, but are not limited to:

> Bleeding, swelling, bruising, discomfort, stiff jaws, infection, aspiration, paresthesia, nerve disturbance or damage either temporary or permanent, adverse drug response, allergic reaction, cardiac arrest.

I realize that it is mandatory that I follow any instructions given by the dentist and/or his/her associates and take any medication as directed.

Alternative treatment options, including no treatment, have been discussed and understood. No guarantees have been made as to the results of treatment. A full explanation of all complications is available to me upon request from the dentist.

Procedure(s): _____

Tooth Number(s): _____

Date: _____

Dentist: _____

Patient Name: _____

Legal Guardian/
Patient Signature: _____

Witness: _____

Note: The above form is intended to be a sample. DentaQuest is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.

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AUTHORIZATION TO HONOR DIRECT AUTOMATED CLEARING HOUSE (ACH) CREDITS DISBURSED BY TEXAS GLOBALHEALTH MEDICARE ADVANTAGE

INSTRUCTIONS

1. Complete all parts of this form.
2. Execute all signatures where indicated. If account requires counter signatures, both signatures must appear on this form.
3. **IMPORTANT:** Attach voided check from checking account.

MAINTENANCE TYPE:

_____ Add
_____ Change (Existing Set-Up)
_____ Delete (Existing Set-Up)

ACCOUNT HOLDER INFORMATION:

Account Number: _____

Account Type: _____Checking

_____Personal _____Business (choose one)

Bank Routing Number: ☐☐☐☐☐☐☐☐☐

Bank Name: _____

Account Holder Name: _____

Effective Start Date: _____

As a convenience to me, for payment of services or goods due me, I hereby request and authorize **GlobalHealth Medicare Advantage** to credit my bank account via Direct Deposit for the (agreed upon dollar amounts and dates.) I also agree to accept my remittance statements online and understand paper remittance statements will no longer be processed.

This authorization will remain in effect until revoked by me in writing. I agree you shall be fully protected in honoring any such credit entry.

I understand in endorsing or depositing this check that payment will be from Federal and State funds and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.

I agree that your treatment of each such credit entry, and your rights in respect to it, shall be the same as if it were signed by me. I fully agree that if any such credit entry be dishonored, whether with or without cause, you shall be under no liability whatsoever.

_____
Date

_____
Phone Number

_____
Print Name

_____
Signature of Depositor (s) (As shown on Bank records for the account, which this authorization applicable.)

_____
Legal Business/Entity Name (As appears on W-9 submitted to DentaQuest)

_____
Tax ID (As appears on W-9 submitted to DentaQuest)

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MEDICAL AND DENTAL HISTORY

Patient Name:_____Date of Birth: _____

Address: _____

Why are you here today _____

Are you having pain or discomfort at this time? ☐ Yes ☐ No

If yes, what type and where? _____

Have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No

Medical Doctor's Name: _____

Address: _____

Telephone: _____

Have you taken any medication or drugs during the past two years? ☐ Yes ☐ No

Are you now taking any medication, drugs, or pills? ☐ Yes ☐ No

If yes, please list medications: _____

Are you aware of being allergic to or have you ever reacted badly to any medication or substance?

☐ Yes ☐ No

If yes, please list: _____

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ☐ Yes ☐ No

Do your ankles swell during the day? ☐ Yes ☐ No

Do you use more than two pillows to sleep? ☐ Yes ☐ No

Have you lost or gained more than 10 pounds in the past year? ☐ Yes ☐ No

Do you ever wake up from sleep and feel short of breath? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No

Has your medical doctor ever said you have cancer or a tumor? ☐ Yes ☐ No

If yes, where? _____

Do you use tobacco products (smoke or chew tobacco)? ☐ Yes ☐ No

If yes, how often and how much? _____

Do you drink alcoholic beverages (beer, wine, whiskey, etc.)? ☐ Yes ☐ No

Do you have or have you had any disease, or condition not listed? ☐ Yes ☐ No

If yes, please list: _____

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Indicate which of the following you have had or have at present. Circle "Yes" or "No" for each item.

Heart Disease or Attack	⌋ Yes	⌋ No	Stroke	⌋ Yes	⌋ No	Hepatitis C	⌋ Yes	⌋ No
Heart Failure	⌋ Yes	⌋ No	Kidney Trouble	⌋ Yes	⌋ No	Arteriosclerosis (hardening of arteries)	⌋ Yes	⌋ No
Angina Pectoris	⌋ Yes	⌋ No	High Blood Pressure	⌋ Yes	⌋ No	Ulcers	⌋ Yes	⌋ No
Congenital Heart Disease	⌋ Yes	⌋ No	Venereal Disease	⌋ Yes	⌋ No	AIDS	⌋ Yes	⌋ No
Diabetes	⌋ Yes	⌋ No	Heart Murmur	⌋ Yes	⌋ No	Blood Transfusion	⌋ Yes	⌋ No
HIV Positive	⌋ Yes	⌋ No	Glaucoma	⌋ Yes	⌋ No	Cold sores/Fever blisters/ Herpes	⌋ Yes	⌋ No
High Blood Pressure	⌋ Yes	⌋ No	Cortisone Medication	⌋ Yes	⌋ No	Artificial Heart Valve	⌋ Yes	⌋ No
Mitral Valve Prolapse	⌋ Yes	⌋ No	Cosmetic Surgery	⌋ Yes	⌋ No	Heart Pacemaker	⌋ Yes	⌋ No
Emphysema	⌋ Yes	⌋ No	Anemia	⌋ Yes	⌋ No	Sickle Cell Disease	⌋ Yes	⌋ No
Chronic Cough	⌋ Yes	⌋ No	Heart Surgery	⌋ Yes	⌋ No	Asthma	⌋ Yes	⌋ No
Tuberculosis	⌋ Yes	⌋ No	Bruise Easily	⌋ Yes	⌋ No	Yellow Jaundice	⌋ Yes	⌋ No
Liver Disease	⌋ Yes	⌋ No	Rheumatic fever	⌋ Yes	⌋ No	Rheumatism	⌋ Yes	⌋ No
Arthritis	⌋ Yes	⌋ No	Epilepsy or Seizures	⌋ Yes	⌋ No	Fainting or Dizzy Spells	⌋ Yes	⌋ No
Allergies or Hives	⌋ Yes	⌋ No	Nervousness	⌋ Yes	⌋ No	Chemotherapy	⌋ Yes	⌋ No
Sinus Trouble	⌋ Yes	⌋ No	Radiation Therapy	⌋ Yes	⌋ No	Drug Addiction	⌋ Yes	⌋ No
Pain in Jaw Joints	⌋ Yes	⌋ No	Thyroid Problems	⌋ Yes	⌋ No	Psychiatric Treatment	⌋ Yes	⌋ No
Hay Fever	⌋ Yes	⌋ No	Hepatitis A (infectious)	⌋ Yes	⌋ No			
Artificial Joints (Hip, Knee, etc.)	⌋ Yes	⌋ No	Hepatitis B (serum)	⌋ Yes	⌋ No			

For Women Only:

Are you pregnant? ☐ Yes ☐ No

If yes, what month? _____

Are you nursing? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully.

Patient Signature:_____ Date: _____

Dentist's Signature:_____ Date: _____

Review Date	Changes in Health Status	Patient's signature	Dentist's Signature

Note: The above form is intended to be a sample. DentaQuest is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.

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DentaQuest

Provider Update Form - Provider Operations

Section 1: Current Information - *Complete for all requests*

Provider Last Name | Provider First Name

Individual National Provider Identifier (NPI) #

Telephone Number: | Credentialing E-mail:

☐ **Section 2: Name Change/Demographic Change**

New Name (Last, First, MI)

New Telephone Number: | New Credentialing E-mail:

Date of Birth: | Social Security #: | Gender: | New Fax Number:

☐ **Section 3: Add a Location (*Updated W9 and contract are required for location updates.)**

Location Name:

Service Location Address:

City: | State: | Zipcode:

Telephone: | Credentialing E-mail:

Fax: | Tax ID Number:

New Location Office Hours: | Ages: | Languages: | Handicapped accesible ☐ | Primary Location ☐

Effective Date: | Medicaid id number (if applicable):

☐ **Section 4: Credentialing Correspondence Address Change**

Credentialing Contact Name:

Credentialing Address:

City: | State: | Zipcode:

Telephone: | Credentialing E-mail:

Fax:

☐ **Section 5: Tax ID Change (*Updated W9 and contract are required for Tax ID number changes)**

Old Tax ID Number: | *New Tax ID Number:

Business Name:

Payment Address:

☐ **Section 6: Provider Status Change**

◯ Term provider at location listed below (Please attach document with any additional locations to be termed)

◯ Term provider at all locations - all networks (Please attach term letter, note or document from provider as applicable)

Term Reason/Comments:

Location Name:

Service Location Address:

City: | State: | Zipcode:

Section 7: Requestor Information

Requestor Name | Date:

Requestor Title

Requestor Phone # | Email address:

Section 8: Notes

You may send this form by fax to 262-241-4077 or by email to StandardUpdates@dentaquest.com

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Request for Transfer of Records

I, _____, hereby request and give my permission to

Dr. _____ to provide Dr. _____ any and all

Information regarding past dental care for _____.

Such records may include medical care and treatment, illness or injury, dental history, medical history, consultation, prescriptions, radiographs, models and copies of all dental records and medical records.

Please have these records sent to:

_____

_____

_____

Signed: _____ Date: _____

(Patient)

Signed: _____Date: _____

(Parent, Legal Guardian, or Custodian of the Patient, if Patient is a Minor)

Address: _____

Address: _____

Phone: _____

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Appendix B

Covered Benefits (See Exhibits)

This section identifies covered benefits, provides specific criteria for coverage and defines individual age and benefit limitations for Members enrolled in the program. **Providers with benefit questions should contact DentaQuest's Customer Service Department directly at 1-888-308-9345**

Dental offices are not allowed to charge Members for missed appointments. Plan Members are to be allowed the same access to dental treatment, as any other patient in the dental practice. Private reimbursement arrangements may be made only for non-covered services.

DentaQuest recognizes tooth letters "A" through "T" for primary teeth and tooth numbers "1" to "32" for permanent teeth. Supernumerary teeth should be designated by "AS through TS" for primary teeth and tooth numbers "51" to "82" for permanent teeth. These codes must be referenced in the patient's file for record retention and review. **All dental services performed must be recorded in the patient record, which must be available as required by your Participating Provider Agreement.**

For reimbursement, DentaQuest Providers should bill only per unique surface regardless of location. For example, when a dentist places separate fillings in both occlusal pits on an upper permanent first molar, the billing should state a one surface occlusal amalgam ADA code D2140. Furthermore, DentaQuest will reimburse for the total number of surfaces restored per tooth, per day; (i.e. a separate occlusal and buccal restoration on tooth 30 will be reimbursed as 1 (OB) two surface restoration).

The DentaQuest claim system can only recognize dental services described using the current American Dental Association CDT code list or those as defined as a Covered Benefit. All other service codes not contained in the following tables will be rejected when submitted for payment. A complete, copy of the CDT book can be purchased from the American Dental Association at:

American Dental Association
211 E. Chicago Ave.
Chicago, IL 60611
1-800-947-4746

Furthermore, DentaQuest subscribes to the definition of services performed as described in the CDT manual.

The benefit tables (Exhibits) are all inclusive for covered services. Each category of service is contained in a separate table and lists:

1. The ADA approved service code to submit when billing,
2. Brief description of the covered service,
3. Any age limits imposed on coverage,
4. A description of documentation, in addition to a completed 2018 ADA claim form, that must be submitted when a claim or request for prior authorization is submitted,
5. An indicator of whether or not the service is subject to prior authorization, any other applicable benefit limitations.

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Diagnostic services include the oral examinations, and selected radiographs needed to assess the oral health, diagnose oral pathology, and develop an adequate treatment plan for the member's oral health.
Reimbursement for some or multiple x-rays of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the allowance for a full mouth series.
Reimbursement for radiographs is limited to when required for proper treatment and/or diagnosis.
DentaQuest utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health.
However, please consult the following benefit tables for benefit limitations.
All radiographs must be of diagnostic quality, properly mounted, dated and identified with the member's name. Radiographs not of diagnostic quality will not be reimbursed for, or if already paid for, DentaQuest will recoup the funds previously paid.

Diagnostic and Preventative covered codes are excluded from the members annual maximum allowable.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	21 and older		No	Two of (D0120, D0160, D0170) per 12 Month(s) Per patient.	
D0140	limited oral evaluation-problem focused	21 and older		No	Three of (D0140) per 12 Month(s) Per patient. Not allowed with routine services.	
D0150	comprehensive oral evaluation - new or established patient	21 and older		No	One of (D0150, D0180) per 36 Month(s) Per Provider OR Location. One of (D0120, D0150, D0180) per 6 Month(s) Per Provider OR Location.	
D0160	detailed and extensive oral eval-problem focused, by report	21 and older		No	Two of (D0120, D0160, D0170) per 12 Month(s) Per patient.	
D0170	re-evaluation, limited problem focused	21 and older		No	Two of (D0120, D0160, D0170) per 12 Month(s) Per patient.	
D0180	comprehensive periodontal evaluation - new or established patient	21 and older		No	One of (D0150, D0180) per 36 Month(s) Per Provider OR Location. One of (D0120, D0150, D0180) per 6 Month(s) Per Provider OR Location.	
D0210	intraoral - complete series of radiographic images	21 and older		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient.	
D0220	intraoral - periapical first radiographic image	21 and older		No	One of (D0220) per 1 Day(s) Per patient.	
D0230	intraoral - periapical each additional radiographic image	21 and older		No		

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Exhibit A Benefits Covered for
GlobalHealth Classic HMO 001-GlobalHealth Special Care-GlobalHealth Special Care Savings HMO C-SNP

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0240	intraoral - occlusal radiographic image	21 and older		No	Two of (D0240) per 24 Month(s) Per patient.	
D0270	bitewing - single radiographic image	21 and older		No	One of (D0270, D0272, D0273, D0274) per 12 Month(s) Per patient.	
D0272	bitewings - two radiographic images	21 and older		No	One of (D0270, D0272, D0273, D0274) per 12 Month(s) Per patient.	
D0273	bitewings - three radiographic images	21 and older		No	One of (D0270, D0272, D0273, D0274) per 12 Month(s) Per patient.	
D0274	bitewings - four radiographic images	21 and older		No	One of (D0270, D0272, D0273, D0274) per 12 Month(s) Per patient.	
D0277	vertical bitewings - 7 to 8 films	21 and older		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient.	
D0330	panoramic radiographic image	21 and older		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient.	

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Preventive services include the oral examinations, and selected radiographs needed to assess the oral health, diagnose oral pathology, and develop an adequate treatment plan for the member's oral health.
Reimbursement for some or multiple x-rays of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the allowance for a full mouth series.
Reimbursement for radiographs is limited to when required for proper treatment and/or diagnosis.
DentaQuest utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health.
However, please consult the following benefit tables for benefit limitations.
All radiographs must be of diagnostic quality, properly mounted, dated and identified with the member's name. Radiographs not of diagnostic quality will not be reimbursed for, or if already paid for, DentaQuest will recoup the funds previously paid.
Diagnostic and Preventative covered codes are excluded from the members annual maximum allowable.

***D4346 & D4910 are considered preventative codes which are excluded from the member's annual maximum allowable.
***D9110-Palliative (emergency) treatment of dental pain - minor procedure and D9995-D9996-Teledentistry- are considered preventative codes which are excluded from the member's annual maximum allowable.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	21 and older		No	Two of (D1110, D4346, D4910) per 12 Month(s) Per patient.	
D1206	topical application of fluoride varnish	21 and older		No	Two of (D1206, D1208, D9910) per 12 Month(s) Per patient.	
D1208	topical application of fluoride - excluding varnish	21 and older		No	Two of (D1206, D1208, D9910) per 12 Month(s) Per patient.	

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Members can be billed for any covered services that exceed the annual max (at the contracted rate) and non-covered services as long as they are notified by the provider ahead of time and agree to pay for such services in writing. No prior authorization requirements.
When restorations involving multiple surfaces are requested or performed, that are outside the usual anatomical expectation, the allowance is limited to that of a one-surface restoration. Any fee charged in excess of the allowance for the one-surface restoration is DISALLOWED.
Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances
$1,000 Annual Maximum

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	
D2331	resin-based composite - two surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	

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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2332	resin-based composite - three surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	
D2390	resin-based composite crown, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	
D2391	resin-based composite - one surface, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	
D2392	resin-based composite - two surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	
D2393	resin-based composite - three surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	

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Exhibit A Benefits Covered for
GlobalHealth Classic HMO 001-GlobalHealth Special Care-GlobalHealth Special Care Savings HMO C-SNP

Members can be billed for any covered services that exceed the annual max (at the contracted rate) and non-covered services as long as they are notified by the provider ahead of time and agree to pay for such services in writing. Claims for preventive dental procedure codes D1110, D1206, and D1208 will be denied when submitted for the same DOS as any D4000 series periodontal procedure codes.
Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the Diagnostic and Preventative covered codes are excluded from the members annual maximum allowable.

$1,000 Annual Maximum
***D4346 & D4910 are considered preventative codes which are excluded from the members annual maximum allowable.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4341	periodontal scaling and root planing - four or more teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4342	periodontal scaling and root planing - one to three teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4341, D4342) per 36 Month(s) Per patient per quadrant.	
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	21 and older		No	Two of (D1110, D4346, D4910) per 12 Month(s) Per patient.	
D4355	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	21 and older		No	One of (D4355) per 36 Month(s) Per patient.	
D4910	periodontal maintenance procedures	21 and older		No	Four of (D4910) per 12 Month(s) Per patient.	

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Reimbursement includes local anesthesia and routine post-operative care.
The extraction of asymptomatic impacted teeth is not a covered benefit. Symptomatic conditions would include pain and/or infection.
The incidental removal of a cyst or lesion attached to the root(s) of an extraction is considered part of the extraction or surgical fee and should not be billed as a separate procedure.

$1,000 Annual Maximum

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	One of (D7140) per 1 Lifetime Per patient per tooth.	
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	One of (D7210) per 1 Lifetime Per patient per tooth.	pre-operative radiographs
D7220	removal of impacted tooth-soft tissue	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	One of (D7220) per 1 Lifetime Per patient per tooth.	
D7230	removal of impacted tooth-partially bony	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	One of (D7230) per 1 Lifetime Per patient per tooth.	
D7240	removal of impacted tooth-completely bony	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	One of (D7240) per 1 Lifetime Per patient per tooth.	
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	One of (D7241) per 1 Lifetime Per patient per tooth.	

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Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7250	surgical removal of residual tooth roots (cutting procedure)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	One of (D7250) per 1 Lifetime Per patient per tooth.	pre-operative radiographs
D7251	Coronectomy-intentional partial tooth removal is performed when a neurovascular complication is likely if the entire impacted tooth is removed.	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	One of (D7251) per 1 Lifetime Per patient per tooth.	pre-operative radiographs

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Local anesthesia is considered part of the treatment procedure, and no additional payment will be made for it. Adjunctive general services include: IV sedation and emergency services provided for relief of dental pain.
Covered dental services that indicate "Yes" in the "Review Required" column require documentation of medical necessity and will be subject to clinical review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the "Documentation Required" column) with the claim form. Providers should always check the member's eligibility and remaining benefit maximum prior to rendering services.
Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances

$1,000 Annual Maximum

***D9110-Palliative (emergency) treatment of dental pain - minor procedure and D9995-D9996-Teledentistry- are considered preventative codes which are excluded from the member's annual maximum allowable.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9110	palliative (emergency) treatment of dental pain - minor procedure	21 and older		No	Not allowed with anything other than D0140 and x-rays.	
D9995	teledentistry – synchronous; real-time encounter	21 and older		No	One of (D9995, D9996) per 1 Day(s) Per Provider OR Location. Cannot be billed as standalone code. D9995 or D9996 must be billed with exam code.	
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	21 and older		No	One of (D9995, D9996) per 1 Day(s) Per Provider OR Location. Cannot be billed as standalone code. D9995 or D9996 must be billed with exam code.	

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Exhibit B Benefits Covered for
GlobalHealth Classic HMO 003

Diagnostic services include the oral examinations, and selected radiographs needed to assess the oral health, diagnose oral pathology, and develop an adequate treatment plan for the member's oral health.
Reimbursement for some or multiple x-rays of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the allowance for a full mouth series.
Reimbursement for radiographs is limited to when required for proper treatment and/or diagnosis.
DentaQuest utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health.
However, please consult the following benefit tables for benefit limitations.
All radiographs must be of diagnostic quality, properly mounted, dated and identified with the member's name. Radiographs not of diagnostic quality will not be reimbursed for, or if already paid for, DentaQuest will recoup the funds previously paid.
Diagnostic and Preventative covered codes are excluded from the members annual maximum allowable.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	21 and older		No	One of (D0120, D0160, D0170) per 12 Month(s) Per patient.	
D0140	limited oral evaluation-problem focused	21 and older		No	Three of (D0140) per 12 Month(s) Per patient. Not allowed with routine services.	
D0150	comprehensive oral evaluation - new or established patient	21 and older		No	One of (D0120, D0150, D0180) per 6 Month(s) Per Provider OR Location. One of (D0150, D0180) per 36 Month(s) Per Provider OR Location.	
D0160	detailed and extensive oral eval-problem focused, by report	21 and older		No	Two of (D0120, D0160, D0170) per 12 Month(s) Per patient.	
D0170	re-evaluation, limited problem focused	21 and older		No	Two of (D0120, D0160, D0170) per 12 Month(s) Per patient.	
D0180	comprehensive periodontal evaluation - new or established patient	21 and older		No	One of (D0150, D0180) per 36 Month(s) Per Provider OR Location. One of (D0120, D0150, D0180) per 6 Month(s) Per Provider OR Location.	
D0210	intraoral - complete series of radiographic images	21 and older		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient.	
D0220	intraoral - periapical first radiographic image	21 and older		No	One of (D0220) per 1 Day(s) Per patient.	
D0230	intraoral - periapical each additional radiographic image	21 and older		No		
D0240	intraoral - occlusal radiographic image	21 and older		No	Two of (D0240) per 24 Month(s) Per patient.	

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Exhibit B Benefits Covered for GlobalHealth Classic HMO 003

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0270	bitewing - single radiographic image	21 and older		No	One of (D0270, D0272, D0273, D0274) per 12 Month(s) Per patient.	
D0272	bitewings - two radiographic images	21 and older		No	One of (D0270, D0272, D0273, D0274) per 12 Month(s) Per patient.	
D0273	bitewings - three radiographic images	21 and older		No	One of (D0270, D0272, D0273, D0274) per 12 Month(s) Per patient.	
D0274	bitewings - four radiographic images	21 and older		No	One of (D0270, D0272, D0273, D0274) per 12 Month(s) Per patient.	
D0277	vertical bitewings - 7 to 8 films	21 and older		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient.	
D0330	panoramic radiographic image	21 and older		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient.	

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Exhibit B Benefits Covered for
GlobalHealth Classic HMO 003

Preventive services include the oral examinations, and selected radiographs needed to assess the oral health, diagnose oral pathology, and develop an adequate treatment plan for the member's oral health.
Reimbursement for some or multiple x-rays of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the allowance for a full mouth series.
Reimbursement for radiographs is limited to when required for proper treatment and/or diagnosis.
DentaQuest utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health.
However, please consult the following benefit tables for benefit limitations.
All radiographs must be of diagnostic quality, properly mounted, dated and identified with the member's name. Radiographs not of diagnostic quality will not be reimbursed for, or if already paid for, DentaQuest will recoup the funds previously paid.
Diagnostic and Preventative covered codes are excluded from the members annual maximum allowable.

***D4346 & D4910 are considered preventative codes which are excluded from the member's annual maximum allowable.
***D9110-Palliative (emergency) treatment of dental pain - minor procedure and D9995-D9996-Teledentistry- are considered preventative codes which are excluded from the member's annual maximum allowable.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	21 and older		No	Two of (D1110, D4346, D4910) per 12 Month(s) Per patient.	
D1206	topical application of fluoride varnish	21 and older		No	Two of (D1206, D1208) per 12 Month(s) Per patient.	
D1208	topical application of fluoride - excluding varnish	21 and older		No	Two of (D1206, D1208) per 12 Month(s) Per patient.	

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Exhibit B Benefits Covered for
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Members can be billed for any covered services that exceed the annual max (at the contracted rate) and non-covered services as long as they are notified by the provider ahead of time and agree to pay for such services in writing. Claims for preventive dental procedure codes D1110, D1206, and D1208 will be denied when submitted for the same DOS as any D4000 series periodontal procedure codes.

$1,000 Annual Maximum

***D4346 & D4910 are considered preventative codes which are excluded from the members annual maximum allowable.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	21 and older		No	Two of (D1110, D4346, D4910) per 12 Month(s) Per patient.	
D4910	periodontal maintenance procedures	21 and older		No	Four of (D4910) per 12 Month(s) Per patient.	

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Local anesthesia is considered part of the treatment procedure, and no additional payment will be made for it. Adjunctive general services include: IV sedation and emergency services provided for relief of dental pain.
Covered dental services that indicate "Yes" in the “Review Required” column require documentation of medical necessity and will be subject to clinical review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the "Documentation Required" column) with the claim form. Providers should always check the member’s eligibility and remaining benefit maximum prior to rendering services.
Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances

$1,000 annual max

***D9110-Palliative (emergency) treatment of dental pain - minor procedure and D9995-D9996-Teledentistry- are considered preventative codes which are excluded from the member's annual maximum allowable.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9110	palliative (emergency) treatment of dental pain - minor procedure	21 and older		No	Not allowed with anything other than D0140 and x-rays.	
D9995	teledentistry – synchronous; real-time encounter	21 and older		No	One of (D9995, D9996) per 1 Day(s) Per Provider OR Location. Cannot be billed as standalone code. D9995 or D9996 must be billed with exam code.	
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	21 and older		No	One of (D9995, D9996) per 1 Day(s) Per Provider OR Location. Cannot be billed as standalone code. D9995 or D9996 must be billed with exam code.	

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